DEPARTMENT OF SOCIAL SERVICES MEDICAL SERVICES

ACKNOWLEDGEMENT OF INFORMATION FOR HYSTERECTOMY

| Prior to having a hystere | ctomy, I understand/understood and fully acknowledge | |
|---|--|--|
| that the surgical procedure of hysterectomy renders me permanently sterile. | | |
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| | | |
| Date | Signature | |
| | | |

The Medicaid recipient must sign and date the Acknowledgment of Information form prior to Medicaid payment.